IPDR6702				NORTH CAROLINA		P	AGE: 1	
	05/06/2007			RS CHECKWRITE SUMMARY REPORT				
				CHECKWRITE DATE: 05/08/2007				
			1	FINANCIAL PAYER: NCDMH				
							TOTAL	TOTAL
PROVIDER NUMBER		HIGH DENIAL EOBS	NUMBER OF DENIALS	DESCRIPTION	TNC	TOTAL	CLAIMS	CLAIMS
NAMMUNI	PROVIDER NAME	EUBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404901	SMOKY MOUNTAINM	8505	957	CLAIM DENIED DUE TO INSUFFICIE				
	H/DD/SAS			NT BUDGET				
		8537	461	PROCEDURE IS NOT PAYABLE FOR Y	19	2316	2327	11
				OUR PROVIDER TYPE AND SPECIALTY IN ACCORDANCE TO MEN				
				SPECIALII IN ACCORDANCE TO MEN				
		8508	358	CLAIM DENIED NO BUDGET FOUND				
3404904	WESTERN HIGHLAN	8654	205	ONLY 16 UNITS ALLOWED PER DAY				
	DS LME			WITHOUT PRIOR				
				APPROVAL. PLEASE CORRECT THE				
		79	111	THIS SERVICE IS NOT PAYABLE TO	0	472	16081	15609
			1	YOUR SUBMITTED BILLING				
				PROVIDER TYPE AND SPECIALTY IN			<del> </del>	
		191	39	CLIENT ID NUMBER DOES NOT MATC				<del>                                     </del>
				H PATIENT NAME				
							<del>                                     </del>	
3404910	PATHWAYS	21	1052	DUPLICATE OF CLAIM-SYSTEM				
							<del></del>	
		8599	152	DETAIL NOT COVERED BY COMBINAT	29	1764	10506	8699
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		8536	99	ATTENDING PROVIDER TYPE AND SP				
				ECIALTY COMBINATION IS NOT				
				VALID FOR SUBMITTED BILLING PR				
3404912	CATAWBA COUNTYM	8599	25	DETAIL NOT COVERED BY COMBINAT				
	ENTAL HEALT			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		191	6	CLIENT ID NUMBER DOES NOT MATC	1	35	4934	4899
			-	H PATIENT NAME	1	35	4934	4033
		8649	2	CLAIM DENIED MAXIMUM ALLOWED 2				
			-	6 OCCURRENCES HAVE PROCESSED				
				AND PAID, PA IS REQUIRED.				
3404913		8505	4372	CLAIM DENIED DUE TO INSUFFICIE				
3404913	MECKLENBURG COM ENTAL HEALT	8505	4372	NT BUDGET			<del>                                     </del>	
		9500	1617	DETAIL NOT COVERED BY COMBINAT				
		8599	1617	ION OF RECIPIENT, PROVIDER AND	262	11547	13361	1814
				BENEFIT PACKAGE.				
		70	052	THIS SERVICE IS NOT PAYABLE TO			<u> </u>	
		79	953	THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING			<del>                                     </del>	
	<u> </u>			PROVIDER TYPE AND SPECIALTY IN			<u> </u>	
2404916		8505	64	CLAIM DENIED DUE TO INSUFFICIE				
3404916	CROSSROADS BEHA VIORAL HEAL	0505	04	CLAIM DENIED DUE TO INSUFFICIE  NT BUDGET			<del>                                     </del>	
	OACHD ALLAND						1	
		8800		BIDWIED PROGRAMMY WASHANA				
		8800	2	FURTHER PROCESSING NECESSARY, PLEASE CHECK FOR CLAIM ON	0	81	149	68
			1	FUTURE RA'S.				
		5404	_					
		5404	2	SEVERE DUPLICATE: SAME ATTD PR OV/PCODE/TOS/DOS/MOD			<del> </del>	
							1	<del>                                     </del>
3404917	CENTERPOINT HUM	8505	327	CLAIM DENIED DUE TO INSUFFICIE  NT BUDGET			<del>                                     </del>	
	AN SERVICES		1	NA DODGET			<del>                                     </del>	-
		8599	60	DETAIL NOT COVERED BY COMBINAT	0	526	3217	2691
				ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.			<del> </del>	
	+	+	1		+		t	<del>                                     </del>
		11	31	CLIENT NOT ELIGIBLE ON SERVICE DATE				

PROVIDER							TOTAL	TOTAL
PROVIDER		HIGH DENIAL	NUMBER OF		TNC	TOTAL	CLAIMS	CLAIMS
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404919	GUILFORD CO MEN	8505	1456	CLAIM DENIED DUE TO INSUFFICIE				
	TAL HEALTHC			NT BUDGET				
		8800	357	FURTHER PROCESSING NECESSARY,	0	1830	1841	11
				PLEASE CHECK FOR CLAIM ON				
				FUTURE RA'S.				
		11	1.4	CLIENT NOT ELIGIBLE ON SERVICE				
		11	14					
				DATE				
3404920		8505	552	CLAIM DENIED DUE TO INSUFFICIE				
3101320	ALAMANCE CASWEL L AREA MH D	0303	332	NT BUDGET				
	L AREA MH D							
		79	286	THIS SERVICE IS NOT PAYABLE TO	0	1271	3575	2304
				YOUR SUBMITTED BILLING	0	12/1	33/3	2304
				PROVIDER TYPE AND SPECIALTY IN				
		21	202	DUPLICATE OF CLAIM-SYSTEM				
			1	-				
			1	+				
				†				
3404921	ORANGE PERSON C	5312	1323	PRIOR AUTHORIZED DOLLARS EXCEE				
	HATHAM AREA		1	DED	1			
			1		1			
	1		1		1			
		8505	1065	CLAIM DENIED DUE TO INSUFFICIE	0	3093	4920	1827
				NT BUDGET		2333	3,720	
		21	260	DUPLICATE OF CLAIM-SYSTEM				
3404922	THE DURHAM CENT	8505	5382	CLAIM DENIED DUE TO INSUFFICIE				
	ER			NT BUDGET				
		8800	763	FURTHER PROCESSING NECESSARY,	28	6778	8066	1288
				PLEASE CHECK FOR CLAIM ON				
				FUTURE RA'S.				
		21	496	DUPLICATE OF CLAIM-SYSTEM				
3404923	FIVE COUNTY MH	191	61	CLIENT ID NUMBER DOES NOT MATC				
				H PATIENT NAME				
		0500	40	PRINTY NOT GOVERNO BY GOVERNO				
		8599	49	DETAIL NOT COVERED BY COMBINAT	0	195	4548	4353
				ION OF RECIPIENT, PROVIDER AND				
			1	BENEFIT PACKAGE.	1			
		21	21	DUDITCATE OF CLAIM-OVOTEM	-			
ļ		21	21	DUPLICATE OF CLAIM-SYSTEM	1			
	-		+					
							I .	1
3404925	CAMPUTITE CENTER	8505	761	CLAIM DENIED DUE TO INSUFFICIR				
3404925	SANDHILLS CENTE	8505	761	CLAIM DENIED DUE TO INSUFFICIE NT BUDGET				
3404925	SANDHILLS CENTE R FOR MH/DD	8505	761	CLAIM DENIED DUE TO INSUFFICIE NT BUDGET				
3404925		8505	761					
3404925				NT BUDGET	24	1220	5712	4397
3404925		8505	761		24	1330	5713	4383
3404925				NT BUDGET	24	1330	5713	4383
3404925				NT BUDGET	24	1330	5713	4383
3404925				NT BUDGET	24	1330	5713	4383
3404925		21	157	NT BUDGET  DUPLICATE OF CLAIM-SYSTEM	24	1330	5713	4383
3404925		21	157	NT BUDGET  DUPLICATE OF CLAIM-SYSTEM  ATTENDING PROVIDER TYPE AND SP	24	1330	5713	4383
3404925		21	157	NT BUDGET  DUPLICATE OF CLAIM-SYSTEM  ATTENDING PROVIDER TYPE AND SP  ECIALTY COMBINATION IS NOT	24	1330	5713	4383
3404925		21	157	NT BUDGET  DUPLICATE OF CLAIM-SYSTEM  ATTENDING PROVIDER TYPE AND SP ECIALTY COMBINATION IS NOT VALID FOR SUBMITTED BILLING PR  DETAIL NOT COVERED BY COMBINAT	24	1330	5713	4383
	R FOR MH/DD	21 8536	157	NT BUDGET  DUPLICATE OF CLAIM-SYSTEM  ATTENDING PROVIDER TYPE AND SP  ECTALTY COMBINATION IS NOT  VALID FOR SUBMITTED BILLING PR	24	1330	5713	4383
	R FOR MH/DD	21 8536	157	NT BUDGET  DUPLICATE OF CLAIM-SYSTEM  ATTENDING PROVIDER TYPE AND SP ECIALTY COMBINATION IS NOT VALID FOR SUBMITTED BILLING PR  DETAIL NOT COVERED BY COMBINAT	24	1330	5713	4383
	R FOR MH/DD	21 8536	157	NT BUDGET  DUPLICATE OF CLAIM-SYSTEM  ATTENDING PROVIDER TYPE AND SP ECIALTY COMBINATION IS NOT VALID FOR SUBMITTED BILLING PR  DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND	24	1330	5713	4383
	R FOR MH/DD	21 8536	157	NT BUDGET  DUPLICATE OF CLAIM-SYSTEM  ATTENDING PROVIDER TYPE AND SP ECIALTY COMBINATION IS NOT VALID FOR SUBMITTED BILLING PR  DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.  CLAIM DENIED, SUBMITTED BEYOND	24	1330	5713	
	R FOR MH/DD	21 8536	157	NT BUDGET  DUPLICATE OF CLAIM-SYSTEM  ATTENDING PROVIDER TYPE AND SP ECIALTY COMBINATION IS NOT VALID FOR SUBMITTED BILLING PR  DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.  CLAIM DENIED, SUBMITTED BEYOND FILING TIMBLIMIT. PRIOR				
	R FOR MH/DD	21 8536	157	NT BUDGET  DUPLICATE OF CLAIM-SYSTEM  ATTENDING PROVIDER TYPE AND SP ECIALTY COMBINATION IS NOT VALID FOR SUBMITTED BILLING PR  DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.  CLAIM DENIED, SUBMITTED BEYOND				
	R FOR MH/DD	21 21 8536 8599 8518	157 103 149	NT BUDGET  DUPLICATE OF CLAIM-SYSTEM  ATTENDING PROVIDER TYPE AND SP ECIALTY COMBINATION IS NOT VALID FOR SUBMITTED BILLING PR  DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.  CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE				
	R FOR MH/DD	21 8536	157	NT BUDGET  DUPLICATE OF CLAIM-SYSTEM  ATTENDING PROVIDER TYPE AND SP ECIALTY COMBINATION IS NOT VALID FOR SUBMITTED BILLING PR  DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.  CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE  ATTENDING PROVIDER TYPE AND SP				
	R FOR MH/DD	21 21 8536 8599 8518	157 103 149	NT BUDGET  DUPLICATE OF CLAIM-SYSTEM  ATTENDING PROVIDER TYPE AND SP ECIALTY COMBINATION IS NOT VALID FOR SUBMITTED BILLING PR  DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.  CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE  ATTENDING PROVIDER TYPE AND SP ECIALTY COMBINATION IS NOT				
	R FOR MH/DD	21 21 8536 8599 8518	157 103 149	NT BUDGET  DUPLICATE OF CLAIM-SYSTEM  ATTENDING PROVIDER TYPE AND SP ECIALTY COMBINATION IS NOT VALID FOR SUBMITTED BILLING PR  DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.  CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE  ATTENDING PROVIDER TYPE AND SP				

	T	Т	_		T	T.		
PROVIDER		HIGH DENIAL	NUMBER OF	-	TNC	TOTAL	TOTAL	TOTAL
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404927	CUMBERLAND CO M	8505	570	CLAIM DENIED DUE TO INSUFFICIE				
	HC			NT BUDGET				
		8599	141	DETAIL NOT COVERED BY COMBINAT	,	010	2051	2012
				ION OF RECIPIENT, PROVIDER AND	1	818	2861	2043
				BENEFIT PACKAGE.				
		21	43	DUPLICATE OF CLAIM-SYSTEM				
		-						
3404930	JOHNSTON COUNTY	8599	67	DETAIL NOT COVERED BY COMBINAT				
	MNTL HLTHC			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		8536	45	ATTENDING PROVIDER TYPE AND SP	2	149	1589	1440
				ECIALTY COMBINATION IS NOT VALID FOR SUBMITTED BILLING PR				
			-	VALID FOR SUBMITTED BILLING PR				
		5404	28	SEVERE DUPLICATE: SAME ATTD PR				
			-	OV/PCODE/TOS/DOS/MOD				
3404931	WAKE CO HUM SVC	8534	266	SERVICE FACILITY LOCATION IS N				
	BILLING OF	<u> </u>	<del> </del>	OT A VALID IPRS ATTENDING				
		+	<del> </del>	PROVIDER. PLEASE VERIFY THE F		<del>                                     </del>		
		21	132	DUPLICATE OF CLAIM-SYSTEM	11	866	8455	7589
		+	+		11	866	8455	/589
		1						
		<u> </u>						
		8599	111	DETAIL NOT COVERED BY COMBINAT				
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
3404933	COMMUNICATION OF	8599	79	DETAIL NOT COVERED BY COMBINAT				
3101933	SOUTHEASTERN CT R FOR MH/DD	0333		ION OF RECIPIENT, PROVIDER AND				
	K FOR MII/DD	1		BENEFIT PACKAGE.				
		191	17	CLIENT ID NUMBER DOES NOT MATC	1	167	4581	4414
				H PATIENT NAME				
		143	16	CLIENT ID NUMBER NOT ON STATE				
		113	10	ELIGIBILITY FILE				
		-	-	<u> </u>				
3404934	ONSLOW CARTERET	8599	632	DETAIL NOT COVERED BY COMBINAT				
	BEHAV HEAL			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		8536	260	ATTENDING PROVIDER TYPE AND SP				
		0330	200	ECIALTY COMBINATION IS NOT	0	1798	4493	2695
				VALID FOR SUBMITTED BILLING PR				
		1						
		21	238	DUPLICATE OF CLAIM-SYSTEM				
		<u> </u>	<del>                                     </del>	-				
2404925		0	0	*** NO DATA TO REPORT ***				
3404935	WAYNE CO MENTAL	U U	0	NO DATA TO REPORT^-				
	HEALTH CTR	+	+	+		<del> </del>		
		1	†					
		0	0		0	0	0	0
			L					
3404936	WILSON-GREENE M	8505	254	CLAIM DENIED DUE TO INSUFFICIE  NT BUDGET		ļ		
	ENTAL HEALT		+	NI BODGEI				
	1	+	+	+		<del> </del>		
		8534	21	SERVICE FACILITY LOCATION IS N	0	279	926	647
		1		OT A VALID IPRS ATTENDING		279	- 20	22/
				PROVIDER. PLEASE VERIFY THE F				
		0500		DDM VV NOW GOLDEN				
		8599	2	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND		<b></b>	-	
		+	+	ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
		+	+					
3404937	EDGECOMBE NASH	21	24	DUPLICATE OF CLAIM-SYSTEM				
	MNTL HLTH C	1	1				-	
		1						
		8518	11	CLAIM DENIED, SUBMITTED BEYOND	0	41	1215	1174
			<b></b>	FILING TIMELIMIT. PRIOR				
		+	1	FISCAL YEAR DOS (JULY 1 - JUNE				
	1	191	5	CLIENT ID NUMBER DOES NOT MATC				<b>—</b>
		191	-	H PATIENT NAME				
		191	-					

PROVIDER		HIGH DENIAL	NUMBER OF		TINIC	momar	TOTAL	TOTAL
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	TNC DENIALS	TOTAL	CLAIMS FINALIZED	CLAIMS PAID
3404939	NEUSE MENTAL HE	8599	59	DETAIL NOT COVERED BY COMBINAT				
	ALTH CENTER			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		8534	57	SERVICE FACILITY LOCATION IS N		105	1161	0.71
		0331	J.,	OT A VALID IPRS ATTENDING	0	185	1161	976
				PROVIDER. PLEASE VERIFY THE F				
		191	16	CLIENT ID NUMBER DOES NOT MATC				
				H PATIENT NAME				
3404941	PITT CO MH/DD/S	143	148	CLIENT ID NUMBER NOT ON STATE			-	
	AS CENTER			ELIGIBILITY FILE				
		8599	70	DETAIL NOT COVERED BY COMBINAT	0	407	2813	240
				ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
				BENEFII PACKAGE.				
		120	50	CLIENT ID NUMBER MISSING OR IN				
				VALID. ENTER CID AND SUBMIT				
				AS A NEW CLAIM				
3404942	ROANOKE CHOWANH	3411	13	PROVIDER TYPE AND SPECIALTY 07		L		1
	UMAN SERVIC		1	4/113 CANNOT BILL ENHANCED BENEFIT SERVICES ON OR AFTER D		<del>                                     </del>	<del>                                     </del>	1
				DENSITI SERVICES ON OR AFTER D		<del> </del>	<u> </u>	
	+	7007	2	EXCEEDS MAXIMUM UNITS ALLOWED	0	17	557	540
				PER MONTH(S)	0	17	357	541
		8518	1	CLAIM DENIED, SUBMITTED BEYOND				
				FILING TIMELIMIT. PRIOR				
				FISCAL YEAR DOS (JULY 1 - JUNE				
3404943	ALBEMARLE MENTA	8599	591	DETAIL NOT COVERED BY COMBINAT				
	L HEALTH CE			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		5404	267	SEVERE DUPLICATE: SAME ATTD PR	248	1435	6470	5035
				OV/PCODE/TOS/DOS/MOD				
		8931	160	AMTNC INELIGIBLE TO RECEIVE SE				
				RVICES IN IPRS.				
3404944	EASTPOINTE HUMA	120	43	CLIENT ID NUMBER MISSING OR IN				
	N SERVICES			VALID. ENTER CID AND SUBMIT AS A NEW CLAIM				
				AS A NEW CLAIM				
		191	39	CLIENT ID NUMBER DOES NOT MATC	0	94	5996	5902
				H PATIENT NAME	0	34	3996	5902
		8533	6	SERVICE FACILITY LOCATION CANN				
				OT BE AN ATTENDING PROVIDER IDENTIFIED AS AN INDIVIDUAL.				
	1			IDENTIFIED AS AN INDIVIDUAL.		<del> </del>	-	
3404946	FOOTHILLS AREAM	120	172	CLIENT ID NUMBER MISSING OR IN		<del>                                     </del>		-
	ENTAL HEALT			VALID. ENTER CID AND SUBMIT			<u> </u>	
				AS A NEW CLAIM				
		8599	113	DETAIL NOT COVERED BY COMBINAT	3	599	8611	8012
	-		1	ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.		<del>                                     </del>	<del>                                     </del>	1
				DENETII PACANGE.		<del> </del>	<u> </u>	
	+	8537	78	PROCEDURE IS NOT PAYABLE FOR Y		<del>                                     </del>	<del>                                     </del>	-
	+			OUR PROVIDER TYPE AND				
			<u> </u>	SPECIALTY IN ACCORDANCE TO MEN				
		-						
3404957	TIDELAND MENTAL	8505	99	CLAIM DENIED DUE TO INSUFFICIE		<u> </u>	<u> </u>	
	HEALTH CTR			NT BUDGET		<b></b>	<u> </u>	
						<del> </del>	<u> </u>	-
	+	8800	31	FURTHER PROCESSING NECESSARY,	2	162	1056	894
				PLEASE CHECK FOR CLAIM ON	3	162	1056	094
				FUTURE RA'S.				
		21	16	DUPLICATE OF CLAIM-SYSTEM		<u> </u>		
						<b></b>	<u> </u>	
ı	-		1			<del>                                     </del>	<del>                                     </del>	1
		8534	2	SERVICE FACILITY LOCATION IS N		<del></del>	<del>                                     </del>	<del>                                     </del>
3404979		1	1	OT A VALID IPRS ATTENDING		-		<del></del>
3404979	NEW RIVER AREAM H/DD/SA PRO			OT A VALID IPRS ATTENDING				
3404979	NEW RIVER AREAM H/DD/SA PRO			PROVIDER. PLEASE VERIFY THE F				
3404979				PROVIDER. PLEASE VERIFY THE F				
3404979		8535	1	PROVIDER. PLEASE VERIFY THE F SERVICE FACILITY LOCATION WAS	0	3	3	
3404979		8535	1	PROVIDER. PLEASE VERIFY THE F	0	3	3	O